Member Call Summary

July 18, 2025

Summer Series- Niki Conrad Friendship Haven

Case Management Face-to-Face Requirements

Iowa Medicaid released an Informational Letter on July 17 stating that as of August 1, Case Managers must have at least one face-to-face contact per month for the first three months of enrollment with individuals enrolled in Medicaid Home and Community Based Services (HCBS) Waivers and Habilitation Services program. This requirement applies when a case management-eligible individual newly enrolls with Case Management or when an existing individual first becomes eligible for Case Management.

Following the first three months, the Case Managers must complete at least one contact per month with the individual or their authorized representative. This contact may be face-to-face, virtual, or via telehealth. Written communication does not constitute contact unless there are extenuating circumstances outlined in the enrollee's individualized service plan (ISP).

- If the individual is enrolled in any of the Medicaid HCBS Waivers or those authorized to receive HCBS Habilitation services who have been diagnosed with an Intellectual and/or Developmental Disability, Case Managers must complete at least one, in-home, face-to-face contact every other month
- For those who are not diagnosed with Intellectual and/or Developmental Disability, the Case Manager must complete at least one, in-home, face-to-face contact every three months.

All Case Managers must advise their individuals that face-to-face in-person contact in the individual's place of residence is a requirement of HCBS eligibility. Individuals who have a medical condition or who reside with someone with a medical condition that warrants virtual or telehealth visits, the virtual/telehealth visit must be specifically requested by the individual or their authorized representative and must be supported by annual documentation from a physician attesting to the medical necessity of virtual/telehealth visits.

These requirements are reflected in the managed care plans' contracts section F.12C.08 as amended July 1, 2024, and will be incorporated into the Case Management manual.

If you have questions, please contact Iowa Medicaid Provider Services.

Federal Policy Updates – Revalidation

Revalidation Deadline for Medicare-Certified Nursing Homes Extended to January 1, 2026

The Centers for Medicare and Medicaid Services (CMS) has once again postponed the off-cycle revalidation deadline for Medicare-certified skilled nursing facilities (SNFs). According to a July 17 MLN Connects newsletter, the new compliance deadline is now **January 1, 2026**.

What You Need to Know About Off-Cycle Revalidation

All **Medicare-certified** nursing homes are required to complete this off-cycle revalidation. **Facilities that do not accept Medicare** (i.e., those that only accept Medicaid or private pay) are not subject to this requirement. It's important to note that **CMS has not updated its online Medicare Revalidation List** to reflect these off-cycle revalidations. This means your organization might not show up as needing revalidation, even though it does. If you are unsure whether to submit, check with Iowa's **Medicare Administrative Contractor (MAC), WPS. You can view their Revalidation resources here.**

For Medicare revalidation, "Additional Disclosable Parties" (ADPs) are individuals or entities with influence or control over a skilled nursing facility (SNF), requiring disclosure to CMS. This includes those who exercise operational, financial, or managerial control, lease property, or provide management, administrative, clinical consulting, or accounting/financial services. SNFs must disclose ADPs, their organizational structure, and their relationship to the SNF.

Submitting Your Revalidation

Revalidations must be submitted through **PECOS**. Here are helpful CMS links:

- **CMS Revalidation Webpage:**
  PECOS Enrollment & Revalidation Info
- **Guidance and FAQs (Updated May 2025):**
  CMS 855A Guidance PDF
- **Workflow Instructions (PECOS Submission):**
  PECOS Workflow PDF

Some members have noted that the PECOS workflow screenshots don't match their experience, this is expected. Follow the instructions provided and **do not start a new provider enrollment**.

Still Have Questions?

For help understanding the ADP reporting requirements or other revalidation questions:

- Review the **CMS guidance** linked above.
- Contact CMS directly at **SNFDisclosures@cms.hhs.gov**.
- Reach out to your **MAC**.
- Consult **legal counsel** if you have questions about whether to report specific individuals or entities as ADPs.

If your MAC requests additional documentation or corrections, you will have **30 days from the date of the request** to comply—**not** the overall revalidation deadline.

LeadingAge hosted two webinars—one in **February 2025** and another update in **July 2025**—to help members understand the revalidation process. These are available on the **LeadingAge Learning Hub**. You can view LeadingAge Iowa's webinar Significant Changes to SNF Medicare Revalidation and Disclosure Requirements: What You Need to Know here (passcode: 6^mS@*cm).

CMS Releases FAQ Document on MDS Validation Audit Program

In June, the Centers for Medicare & Medicaid Services (CMS) released an FAQ document on the Skilled Nursing Facility (SNF) Validation Program which includes audits to assess the accuracy of the Minimum Data Set (MDS) based quality measures. The SNF Validation Program is being developed based on Fiscal Year (FY) 2024 and FY 2025 SNF Prospective Payment System (PPS) final rules to ensure that accurate data is being collected for the Value Based Purchasing (VBP) and Quality Reporting Program (QRP). The SNF Validation Program is scheduled to begin this fall for measures in the FY 2027 program year.

What do you need to know?

Healthcare Management Solutions (HMS) is the validation program contract that will be conducting the audits on behalf of CMS through a Data Use Agreement (DUA). SNF providers are randomly selected based on submitting at least one MDS assessment in the calendar year (CY) and in the current FY. However, each SNF can only be selected once per FY. If selected, you will be notified of the audit via the iQIES system in the Provider Preview Reports Folder. This notification will also include how to submit documents and a list of sampled residents selected.

The SNF will need to identify a point of contact (POC) to receive audit-related email notifications. If you need to change the POC at any point, you can click on the original audit link and update the POC. You will have 45 calendar days from the date of the notification to upload the requested documentation.

Medical record documentation must be bundled with each resident's information in a single PDF file. The file must include a specific formatted title that identifies your CCN number and the MDS Assessment ID (see example in question #17 of the FAQ

document). The PDF will be uploaded to a secure website for review. The audit information will include a specific date range that must be included in the medical record documentation. Records that are outside of the established date range, the resident's face sheet, or social security number must not be submitted. Once the individual records have been successfully uploaded as well as when all requested records have been submitted, an email notification will be sent to the POC.

At the conclusion of the audit, a Summary Audit Scoring Report will be uploaded to iQIES including the results for each measure along with detailed results from each sampled assessment and medical chart audited. The reports are for informational purposes only and SNFs will not be penalized for their audit results. These reports will be available within three months of the submission deadline. SNFs that don't comply with the audit may have a 2% reduction in their SNF Annual Payment Update for the FY2027 SNF QRP program year. A noncompliance letter will be sent from the Medicare Administrative Contractor (MAC). If you disagree with the noncompliance letter, you may submit a request for reconsideration to CMS within 30 days from the noncompliance notification letter. Any requests submitted after 30 days will not accepted.

Any questions on the SNF Validation Program can be directed to the help desk at snfvalidation@hcmsllc.com.

Adult Day Survey Updates

In June, the Department of Inspections, Appeals, & Licensing completed an initial certification survey for adult day services. This provider received 10 insufficiencies within a few categories that are outlined below:

- Criminal background checks – the program completed a federal background check but did not complete a SING check as required until after staff were already hired.
- The contractual agreements were missing several required elements including the process and telephone number for filing complaints with DIAL, the process and telephone number for reporting abuse, that the program would provide at least 90-days' notice in the event of program closure, and the admission and discharge criteria for participants.
- Cognitive evaluations were not completed prior to joining the program and evaluations were not completed within 30 days of joining the program.
- The participants record did not include demographic information, primary physician, and emergency contact information.
- Service plans were not based on complete evaluations and were not updated within 30 days of initial participation.

With this initial visit completed there are still two programs exceeding the 36-month recertification period.

DIAL Revises SNF Provider Letter Due to iQIES Transition

The Iowa Department of Inspection, Appeals, and Licensing reported to LeadingAge Iowa that there will be several changes to the survey letters that are emailed with survey reports due to the transition from ASPEN to iQIES. The most significant change is that the "cover letter" will now be a "survey and enforcement letter". Additionally, the formatting of these documents will be different due to formatting limitations in the iQIES software. If you have any questions or feedback regarding these documents, please contact Kellie Van Ree, Director of Clinical Services.

New Member Resources

The Driving Quality: Navigating Healthcare with LeadingAge Illinois and Iowa has a new webcast available on the rehospitalization and emergency department short- and long-stay measures. This edition includes determining the numerator and denominators for each measure and strategies to improve your performance in these claims based measures.

LeadingAge published an updated resource for members regarding immigration enforcement preparedness. This resource is meant to help members prepare for potential interactions with U.S. Immigration and Customs Enforcement (ICE).

Use this Non-Pharmacological Interventions by Behaviors as a quick resource for your staff to avoid the use of psychotropic medications.

AL Rule Review – 481-69.22 – Tenant Evaluations

Assisted living tenants must have evaluations which include assessments of the resident's cognitive, functional, and health status at frequencies identified in 481-69.22. First, let's cover the initial evaluation which must occur prior to the tenant's service plan being developed, the occupancy agreement being completed, and the tenant occupying the assisted living unit. The initial evaluation must include all three elements (cognitive, functional, and health) to be considered compliant.

Cognitive evaluations shall utilize a scored, objective tool. This can include but is not limited to mini-mental status examinations (MMSE), brief interview for mental status (BIMS), or other similar cognitive testing that identifies if the tenant has any cognitive impairments and if they do, the extent of those cognitive impairments. If the score of the objective tool identifies that the tenant has moderate or severe cognitive impairment, the program must complete a Global Deterioration Scale (GDS) which shall be used at subsequent intervals unless the tenant returns to mild cognitive impairment. If this occurs, the program can return to the objective testing completed for other tenants.

Who can complete evaluations?

Health care or human services professionals are able to complete the tenant evaluations in assisted living settings. A health care professional includes a physician, physician assistant, registered nurse, or advanced registered nurse practitioner licensed in Iowa by the respective licensing board. In subsequent rules, it also identifies that a licensed practical nurse (LPN) may complete evaluations. In the rules, it states that an LPN may not complete initial or significant change evaluations; however, the Department of Inspection, Appeals and Licensing (DIAL) expressed that in accordance with a change in the scope of practice, they will not be enforcing these rules pending a formal rule change.

A human services professional includes an individual with a bachelor's degree in a human service field including, but not limited to human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of required education. For example, an individual with an associate's degree in a human service field and two years of experience in a human service field is considered a human service professional.

These terms are defined in 481-67.1.

This rule is routinely cited when evaluations are not completed prior to the service plan being developed, the occupancy agreement being signed, and/or before the tenant took occupancy of the dwelling. These evaluations should drive what care the tenant needs and delegates to the program during their stay at the assisted living. This care is then dictated to direct care staff in the service plan and agreed upon in the occupancy agreement.

Regulatory Review – F568 Accounting and Records of Resident's Funds

In the residents' rights regulations, F568 requires specific accounting practices and maintaining records of funds deposited with the nursing home for the residents. Within this regulation, the nursing home must:

- Establish methods of accounting of the resident's funds based on generally accepted accounting principles.
- Ensure the accounting of resident funds is separate from business funds as well as any other resident's funds.
- The record for the resident's funds must be available to the residents via quarterly statements and upon request.

The interpretative guidance for this regulation includes that the accounting of the resident's funds must include transactions that occurred for the specific resident such as when they occurred, what they were, and an ongoing balance. Additionally, the

residents should be given a receipt of the transaction and the nursing home should retain a copy of the receipt. Finally, quarterly statements are considered timely if provided within 30 days of the end of a quarter and upon request.

This regulation is not frequently cited. However, Appendix PP includes some examples of noncompliance including that the nursing home did not assure the accounting of resident's funds were separate from business funds and not providing the resident the quarterly statements.

Upcoming Events

MDS Virtual Program (virtual)
August 13-15, 2025 from 11 a.m.-3 p.m.

Admit to Discharge: A Rules, Regs, & Reimbursement Blueprint Webinar Series (virtual)
August 20 & 27, 2025 from 1 - 2 p.m. & September 10, 2025 from 1 - 2:30 p.m.

Regional Networking Meeting (in-person)
August 27, 2025 from 1-3 p.m. (The Meth-Wick Community will be hosting lunch at noon for those that are able to come at that time.)
Location: The Meth-Wick Community, 1224 13th St. NW, Cedar Rapids, IA 52405

No Communique or Member Call Next Week

LeadingAge Iowa staff will be in Schaumburg, Illinois for the LeadingAge Illinois Annual Conference next week (July 21 – July 23). Therefore, there will not be a Communique on Thursday, July 24 or a Member Call on Friday, July 25. These will both resume the following week.